

		FOR OHF USE					

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041392</u> Facility Name: <u>HERITAGE MANOR-MINONK</u> Address: <u>201 LOCUST</u> <u>COLFAX</u> <u>61701</u> <div style="display: flex; justify-content: space-around; width: 100%;"> Number City Zip Code </div> County: <u>WOODFORD</u> Telephone Number: <u>(309) 432-2557</u> Fax # <u>()</u> IDPA ID Number: <u>370909086019</u> Date of Initial License for Current Owners: <u>01/01/96</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div>	
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In the event there are further questions about this report, please contact:
Name CRAIG L. ATER **Telephone Number:** (309) 823-7135

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number HERITAGE MANOR-MINONK# 0041392 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	49	Skilled (SNF)	49	17,885	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5	23	Sheltered Care (SC)	23	8,395	5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	10,227	4,720	1,052	15,999	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	7,859	0	7,859	12
13	DD 16 OR LESS					13
14	TOTALS	10,227	12,579	1,052	23,858	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 90.78%)D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? _____

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 1996J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 1996 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 1,052Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☐ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

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	G/L	RECAP CENSUS	DIFF
PP	14056	14056	0
IPA	10557	10557	0
medicare	1052	1052	0
	25665	25665	
IPA BEDHOLDS	330		
PP BEDHOLDS	200		
PP CONVERS	1277		

STATE OF ILLINOIS

Page 3

Facility Name & ID Number HERITAGE MANOR-MINONK

0041392

Report Period Beginning: 01/01/01

Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	122,390	16,171	0	138,561		138,561	2,226	140,787		1
2	Food Purchase		93,447		93,447		93,447	(482)	92,965		2
3	Housekeeping	60,763	8,501		69,264		69,264	0	69,264		3
4	Laundry	49,152	9,043		58,195		58,195	0	58,195		4
5	Heat and Other Utilities			83,237	83,237		83,237	906	84,143		5
6	Maintenance	31,079	22,019	17,634	70,732		70,732	7,139	77,871		6
7	Other (specify):*							0			7
8	TOTAL General Services	263,384	149,181	100,871	513,436		513,436	9,789	523,225		8
	B. Health Care and Programs										
9	Medical Director			363	363		363	0	363		9
10	Nursing and Medical Records	643,289	22,862	3,399	669,550		669,550	0	669,550		10
10a	Therapy		125,414	39,105	164,519	(219,198)	(54,679)	88,638	33,959		10a
11	Activities	26,263	2,088	0	28,351		28,351	0	28,351		11
12	Social Services	18,472	0	1,774	20,246		20,246	0	20,246		12
13	Nurse Aide Training	843	100		943		943	1,331	2,274		13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16		688,867	150,464	44,641	883,972	(219,198)	664,774	89,969	754,743		16
	C. General Administration										
17	Administrative	63,901			63,901		63,901	19,727	83,628		17
18	Directors Fees							3,089	3,089		18
19	Professional Services			156,793	156,793		156,793	(146,913)	9,880		19
20	Dues, Fees, Subscriptions & Promotions			35,688	35,688	(26,828)	8,860	(2,269)	6,591		20
21	Clerical & General Office Expense	51,533	3,418	11,903	66,854		66,854	107,116	173,970		21
22	Employee Benefits & Payroll Taxes			172,084	172,084		172,084	15,205	187,289		22
23	Inservice Training & Education			861	861		861	583	1,444		23
24	Travel and Seminar			4,281	4,281		4,281	(2,282)	1,999		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			16,662	16,662		16,662	1,094	17,756		26
27	Other (specify):*			6,809	6,809		6,809	(6,791)	18		27
28	TOTAL General Administration	115,434	3,418	405,081	523,933	(26,828)	497,105	(11,441)	485,664		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,067,685	303,063	550,593	1,921,341	(246,026)	1,675,315	88,317	1,763,632		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

Facility Name & ID Number **HERITAGE MANOR-MINONK**# **0041392**Report Period Beginning: **01/01/01** Ending: **12/31/01****V. COST CENTER EXPENSES (continued)**

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			61,295	61,295		61,295	4,798	66,093		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			94,049	94,049		94,049	(77)	93,972		32
33	Real Estate Taxes			30,873	30,873		30,873	0	30,873		33
34	Rent-Facility & Grounds			0				4,414	4,414		34
35	Rent-Equipment & Vehicles			1,683	1,683		1,683	10,681	12,364		35
36	Other (specify):*							0			36
37	TOTAL Ownership			187,900	187,900		187,900	19,816	207,716		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers					219,198	219,198	0	219,198		39
40	Barber and Beauty Shops	0	55	0	55		55	0	55		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee					26,828	26,828	0	26,828		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers		55		55	246,026	246,081		246,081		44
45	GRAND TOTAL COST										
	(sum of lines 29, 37 & 44)	1,067,685	303,118	738,493	2,109,296	0	2,109,296	108,133	2,217,429		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **HERITAGE MANOR-MINONK**

0041392

Report Period Beginning: **01/01/01**

Ending: **12/31/01**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	0	35		5
6	Rented Facility Space	(700)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	0	30		9
10	Interest and Other Investment Income	(15)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(482)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	0	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(448)	20		17
18	Fines and Penalties				18
19	Entertainment	(6,429)	24		19
20	Contributions	(95)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(143)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,696)	27		24
25	Fund Raising, Advertising and Promotional	(4,733)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	0	23		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (19,741)		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	127,874		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 127,874		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 108,133		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb HERITAGE MANOR-MINONK

0041392 Report Period Beginning:

01/01/01

Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
A. General Services														
1	Dietary	0	0	2,226	0	0	0	0	0	0	0	0	2,226	1
2	Food Purchase	(482)	0	0	0	0	0	0	0	0	0	0	(482)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	906	0	0	0	0	0	0	0	0	906	5
6	Maintenance	0	0	7,139	0	0	0	0	0	0	0	0	7,139	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(482)	0	10,271	0	0	0	0	0	0	0	0	9,789	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(2,949)	0	0	91,587	0	0	0	0	0	0	88,638	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,331	0	0	0	0	0	0	0	0	1,331	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Program	0	(2,949)	1,331	0	91,587	0	0	0	0	0	0	89,969	16
C. General Administration														
17	Administrative	0	0	19,727	0	0	0	0	0	0	0	0	19,727	17
18	Directors Fees	0	0	3,089	0	0	0	0	0	0	0	0	3,089	18
19	Professional Services	(143)	0	7,575	0	(154,345)	0	0	0	0	0	0	(146,913)	19
20	Fees, Subscriptions & Promotions	(5,181)	0	2,912	0	0	0	0	0	0	0	0	(2,269)	20
21	Clerical & General Office Expenses	0	0	107,116	0	0	0	0	0	0	0	0	107,116	21
22	Employee Benefits & Payroll Taxes	0	0	15,205	0	0	0	0	0	0	0	0	15,205	22
23	Inservice Training & Education	0	0	583	0	0	0	0	0	0	0	0	583	23
24	Travel and Seminar	(6,429)	0	4,147	0	0	0	0	0	0	0	0	(2,282)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,094	0	0	0	0	0	0	0	0	1,094	26
27	Other (specify):*	(6,791)	0	0	0	0	0	0	0	0	0	0	(6,791)	27
28	TOTAL General Administration	(18,544)	0	161,448	0	(154,345)	0	0	0	0	0	0	(11,441)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,026)	(2,949)	173,050	0	(62,758)	0	0	0	0	0	0	88,317	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number: HERITAGE MANOR-MINONK

0041392

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	4,798	0	0	0	0	0	0	0	4,798	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15)	0	0	(62)	0	0	0	0	0	0	0	(77)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(700)	0	0	5,114	0	0	0	0	0	0	0	4,414	34
35	Rent-Equipment & Vehicles	0	0	0	10,681	0	0	0	0	0	0	0	10,681	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(715)	0	0	20,531	0	0	0	0	0	0	0	19,816	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(19,741)	(2,949)	173,050	20,531	(62,758)	0	0	0	0	0	0	108,133	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

Facility Name & ID Number:HERBERT AGE MANOR-MENIONS

STATE OF ILLINOIS

Report Period Beginning:01/01/01

Ending:12/31/01

Page:6

Show Pgs 6A thru 6B

Show Pgs 6B thru 6C

Show Pgs 6A thru 6B

VI. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

OWNERS		RELATED NURSING HOMES		OTHER RELATED BUSINESS ENTITIES	
Name	Ownership %	Name	City	Name	City

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.
☐ Yes ☐ No

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

Schedule V Line	1	2	3	4	5	6	7	8
	Cost to Related Organization	Percent of Ownership	Operating Costs of Related Organization	Adjustments to Related Organization Costs (Section 6)				
1								
2								
3								
4								
5								
6								
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38								
39								
40								
41								
42								
43								
Total								

Print Preview

Total must agree with the amount recorded on line 36 of Schedule V.
DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.
1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1
Line 2
Line 3
Line 4
Line 5
Line 6
Line 7
Line 8
Line 9
Line 10
Line 10a
Line 11
Line 12
Line 13
Line 14
Line 15
Line 16
Line 17
Line 18
Line 19
Line 20
Line 21
Line 22
Line 23
Line 24
Line 25
Line 26
Line 27
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Line 29
Line 30
Line 31
Line 32
Line 33
Line 34
Line 35
Line 36
Line 37
Line 38
Line 39
Line 40
Line 41
Line 42
Line 43

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 2,226	\$ 2,226
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				906	906
20	V	6 Maintenance				7,139	7,139
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				1,331	1,331
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				19,727	19,727
30	V	18 Directors Fees				3,089	3,089
31	V	19 Professional Services				7,575	7,575
32	V	20 Fees, Subscription, Promotion				2,912	2,912
33	V	21 Clerical & General Office Expenses				107,116	107,116
34	V	22 Employee Benefits & Payroll Taxes				15,205	15,205
35	V	23 Inservice Training & Education				583	583
36	V	24 Travel and Seminar				4,147	4,147
37	V	25 Other Admin, Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				1,094	1,094
39	Total		\$			\$ 173,050	\$ * 173,050

Sum_6A

2226

906

7139

1331

19727

3089

7575

2912

107116

15205

583

4147

1094

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number HERITAGE MANOR-MINONK # 0041392 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V 27	Other	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$
16	V 30	Depreciation				4,798	4,798
17	V 31	Amortization of Pre-Op & Org				0	
18	V 32	Interest				(62)	(62)
19	V 33	Real Estate Taxes				0	
20	V 34	Rent-Facility & Grounds				5,114	5,114
21	V 35	Rent-Equipment & Vehicles				10,681	10,681
22	V 36	Other				0	
23	V 38	Medically Nec Transportation				0	
24	V 39	Ancillary Service Centers				0	
25	V 40	Barber and Beauty Shops				0	
26	V 41	Coffee and Gift Shops				0	
27	V 42	Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 20,531	\$ * 20,531

Sum_6B

4798

-62

5114
10681

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number HERITAGE MANOR-MINONK # 0041392 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Adjustment for Related Organization	\$ 154,345	Heritage Enterprises, Inc.		\$	\$ (154,345)
16	V						
17	V	10a Adjustment for Related Organization	125,144	Green Tree Pharmacy	100.00%	216,731	91,587
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 279,489			\$ 216,731	\$ * (62,758)

Sum_6C

-154345

91587

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6E

* Total must agree with the amount recorded on line 34 of Schedule VI.

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6F

Facility Name & ID Number HERITAGE MANOR-MINONK # 0041392 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6F

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

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STATE OF ILLINOIS

Page 6G

Facility Name & ID Number HERITAGE MANOR-MINONK # 0041392 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6G

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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STATE OF ILLINOIS

Page 6H

Facility Name & ID Number HERITAGE MANOR-MINONK

0041392

Report Period Beginnin 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6H

* Total must agree with the amount recorded on line 34 of Schedule VI.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6I

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number HERITAGE MANOR-MINONK# 0041392Report Period Beginning: 01/01/01Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Board	Management	25.98%	28,986	10	0.20	Directors Fees	\$ 767	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Tre	Management	10.15%	28,986	10	0.20	Directors Fees	767	line 18, col 7	2
3	Craig Hart	Secretary/Treasure	Management	20.00%	28,986	10	0.20	Directors Fees	767	line 18, col 7	3
	Joe Warner	President	Management	2.50%	10,352	48	0.95	Directors Fees	274	line 18, col 7	
4	Bill Froelich	Chairman of Board	Management	25.98%	99,994	10	0.20	Salary	2,644	line 17, col 7	4
5	Tom Jefferson	Asst Secretary/Tre	Management	10.15%	98,369	10	0.20	Salary	2,602	line 17, col 7	5
6	Craig Hart	Secretary/Treasure	Management	20.00%	83,113	10	0.20	Salary	2,199	line 17, col 7	6
7	Joe Warner	President	Management	2.50%	111,910	48	0.95	Salary	2,961	line 17, col 7	7
8	Bob Dickson	Executive Vice Pre	Management	0.80%	60,909	50	1.00	Salary	1,611	line 17, col 7	8
9	Cheryl Lowney	Executive Vice Pre	Management	0.31%	51,170	50	1.00	Salary	1,354	line 17, col 7	9
10	Steve Wannemacher	Executive Vice Pre	Management	0.26%	49,529	50	1.00	Salary	1,310	line 17, col 7	10
11	Connie Hoselton	Sr Vice President	Management	0.17%	34,029	40	1.00	Salary	900	line 17, col 7	11
12	Craig Ater	Sr Vice President	Management	0.21%	32,392	50	1.00	Salary	857	line 17, col 7	12
13								TOTAL	\$ 19,013		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
**FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
 ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number HERITAGE MANOR-MINONK# 0041392 Report Period Beginning: 01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Heritage EnterprisesStreet Address 115 W. JeffersonCity / State / Zip Code Bloomington, ILPhone Number ()Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1 Dietary	BEDS	2,328	23	\$ 71,961	\$ 71,961	72	\$ 2,226	1
2	2 Food Purchase	BEDS	2,328	23	0	0	72	0	2
3	3 Housekeeping	BEDS	2,328	23	0	0	72	0	3
4	4 Laundry	BEDS	2,328	23	0	0	72	0	4
5	5 Heat & Other Utilities	BEDS	2,328	23	29,301	0	72	906	5
6	6 Maintenance	BEDS	2,328	23	230,824	54,124	72	7,139	6
7	7 Other	BEDS	2,328	23	0	0	72	0	7
8	9 Medical Director	BEDS	2,328	23	0	0	72	0	8
9	10 Nursing & Medical Records	BEDS	2,328	23	0	0	72	0	9
10	11 Activities	BEDS	2,328	23	0	0	72	0	10
11	12 Social Service	BEDS	2,328	23	0	0	72	0	11
12	13 Nurse Aide Training	BEDS	2,328	23	43,025	0	72	1,331	12
13	14 Program Transportation	BEDS	2,328	23	0	0	72	0	13
14	15 Other	BEDS	2,328	23	0	0	72	0	14
15	17 Administrative	BEDS	2,328	23	637,854	637,854	72	19,727	15
16	18 Directors Fees	BEDS	2,328	23	99,885	0	72	3,089	16
17	19 Professional Services	BEDS	2,328	23	244,928	0	72	7,575	17
18	20 Fees, Subscription, Promotion	BEDS	2,328	23	94,145	0	72	2,912	18
19	21 Clerical & General Office Exp	BEDS	2,328	23	3,463,403	3,114,857	72	107,116	19
20	22 Employee Benefits & Payroll	BEDS	2,328	23	491,614	0	72	15,205	20
21	23 Inservice Training & Education	BEDS	2,328	23	18,866	0	72	583	21
22	24 Travel and Seminar	BEDS	2,328	23	134,093	0	72	4,147	22
23	25 Other Admin. Staff Transport	BEDS	2,328	23	0	0	72	0	23
24	26 Insurance-Prop.Liab.Malprac	BEDS	2,328	23	35,366	0	72	1,094	24
25	TOTALS				\$ 5,595,265	\$ 3,878,796		\$ 173,050	25

Print Preview

Facility Name & ID Number HERITAGE MANOR-MINONK# 0041392 Report Period Beginning: 01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,328	23	\$ 0	\$ 0	72	\$ 0	1
2	30	Depreciation	BEDS	2,328	23	155,150	0	72	4,798	2
3	31	Amortization of Pre-Op & Or	BEDS	2,328	23	0	0	72	0	3
4	32	Interest	BEDS	2,328	23	(1,990)	0	72	(62)	4
5	33	Real Estate Taxes	BEDS	2,328	23	0	0	72	0	5
6	34	Rent-Facility & Grounds	BEDS	2,328	23	165,362	0	72	5,114	6
7	35	Rent-Equipment & Vehicles	BEDS	2,328	23	345,363	0	72	10,681	7
8	36	Other	BEDS	2,328	23	0	0	72	0	8
9	38	Medically Nec Transportation	BEDS	2,328	23	0	0	72	0	9
10	39	Ancillary Service Centers	BEDS	2,328	23	0	0	72	0	10
11	40	Barber and Beauty Shops	BEDS	2,328	23	0	0	72	0	11
12	41	Coffee and Gift Shops	BEDS	2,328	23	0	0	72	0	12
13	42	Other	BEDS	2,328	23	0	0	72	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 663,885	\$		\$ 20,531	25

Facility Name & ID Number HERITAGE MANOR-MINONK# 0041392 Report Period Beginning: 01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number HERITAGE MANOR-MINONK# 0041392 Report Period Beginning: 01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number HERITAGE MANOR-MINONK# 0041392 Report Period Beginning: 01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number HERITAGE MANOR-MINONK# 0041392 Report Period Beginning: 01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LaSalle National Bank		XX	Mortgage	3741+INT	01/26/01	\$ 1,122,188	\$ 1,081,041	01/26/06	variable	\$ 89,777	1	
2	LaSalle Bank Loan Amortization		XX	Mortgage							4,272	2	
3	Central Office Allocation		XX	Interest Income							(62)	3	
4												4	
5												5	
	Working Capital												
6												6	
7											0	7	
8												8	
9	TOTAL Facility Related						\$ 1,122,188	\$ 1,081,041			\$ 93,987	9	
	B. Non-Facility Related*												
10	Interest Income										15	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 15	14	
15	TOTALS (line 9+line14)						\$ 1,122,188	\$ 1,081,041			\$ 93,972	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number **HERITAGE MANOR-MINONK**# **0041392** Report Period Beginning: **01/01/01** Ending: **12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2000 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	29,877	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	29,634	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(243)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	31,116	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6			\$	30,873	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATIC \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax

To Print this page only

**Hold down
Control Key and hit r**

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HERITAGE MANOR-MINONK COUNTY WOODFORD

FACILITY IDPH LICENSE NUMB 0041392

CONTACT PERSON REGARDING THIS REP CRAIG L. ATER

TELEPHONE (309) 823-7135 FAX # ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) Tax Applicable to
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Nursing Home</u>
1. <u>0607407011</u>	<u>HERITAGE MANOR-MINON</u>	\$ <u>20,205</u>	\$ <u>20,205</u>
2. <u>0607407010</u>	<u>HERITAGE MANOR-MINON</u>	\$ <u>9,429</u>	\$ <u>9,429</u>
3. <u> </u>	<u> </u>	\$ <u>0</u>	\$ <u>0</u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u><u>29,634</u></u>	\$ <u><u>29,634</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES xx NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred: _____ **2. Number of Years Over Which it is Being Amortized:** _____

3. Current Period Amortization: _____ **4. Dates Incurred:** _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4
	Use	Square Feet	Year Acquired	Cost
1	Nursing Home		1996	\$ 25,000
2	Nursing Home			
3	TOTALS			\$ 25,000

Print Preview

Facility Name & ID Number HERITAGE MANOR-MINONK

0041392 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72				\$ 1,039,908	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Smoke Detectors (45)			1998	3,267						9
10	Compressor			1998	1,047						10
11	Generator			1998	12,140						11
12	A/C Repair			1998	1,518						12
13	Plumbing Repair			1998	4,956						13
14											14
15	Water Heater			1996	2,603						15
16	Resident Room Renovating			1996	8,483						16
17	Exterior Painting & Renovation			1996	4,806						17
18	Nurse Call System			1996	3,803						18
19	Garbage Disposal			1996	867						19
20	Boiler Repair			1996	4,436						20
21	Receptionist Work Area Renovation			1996	1,260						21
22	Hot Water Heater			1996	505						22
23	Exterior Signage			1996	1,680						23
24	Interior Rehab			1996	146,288						24
25	Interior Rehab			1996	22,963						25
26	Code Alert System			1996	1,319						26
27											27
28	Interior Rehab			1997	33,578						28
29	Interior Rehab			1997	168						29
30	Building Purchase Offset			1997	(141,199)						30
31											31
32											32
33											33
34	C/O Allocation							4,798	4,798		34
35	Book Depreciation					41,250		41,250		187,296	35
36					1,154,396						36

* Total beds on this schedule must agree with page 2.

See page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

0 Page 12B
0 Page 12C
0 Page 12D
0 Page 12E
0 Page 12F
0 Page 12G
0 Page 12H
0 Page 12I

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Door Alarm System	1999	10,116						37
38 Plumbing / Water Heater	1999	3,170						38
39 Sewage Ejector	1999	3,042						39
40								40
41 Water Heater	2000	3,293						41
42 Remove and replace patio	2000	5,890						42
43								43
44 Garbage Disposal	2001	922						44
45 Painting--Hallways/Resident rooms	2001	2,444						45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 28,877	\$ 41,250		\$ 46,048	\$ 4,798	\$ 187,296	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 28,877	\$ 0		\$ 0	\$	\$ 187,296	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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16								16
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18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 28,877	\$ 0		\$ 0	\$ 0	\$ 187,296	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Numbe HERITAGE MANOR-MINONK

0041392

Report Period Beginning:

01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 28,877	\$ 0		\$ 0	\$	\$ 187,296	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 28,877	\$ 0		\$ 0	\$ 0	\$ 187,296	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Numbe HERITAGE MANOR-MINONK

0041392

Report Period Beginning:

01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 28,877	\$ 0		\$ 0	\$	\$ 187,296	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 28,877	\$ 0		\$ 0	\$ 0	\$ 187,296	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

Hold down
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1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 28,877	\$ 0		\$ 0	\$	\$ 187,296	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 28,877	\$ 0		\$ 0	\$ 0	\$ 187,296	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

Hold down
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1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 28,877	\$ 0		\$ 0	\$	\$ 187,296	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 28,877	\$ 0		\$ 0	\$ 0	\$ 187,296	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **HERITAGE MANOR-MINONK**# **0041392**Report Period Beginning: **01/01/01** Ending: **12/31/01****XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 128,883	\$ 20,045	\$ 20,045	\$		\$ 72,271	71
72	Current Year Purchases	5,631						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 134,514	\$ 20,045	\$ 20,045	\$		\$ 72,271	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,342,787	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 61,295	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,093	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,798	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 259,567	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>0</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☒ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO16. Rental Amount for movable equipm: \$ 12,364 Description: Copier, Cell Phone and Central Office Allocation

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____13. /2002 \$ _____14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number HERITAGE MANOR-MINONK # 0041392 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?

☐ YES
☐ NO

If "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☐

COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☐

HOURS PER AIDE _____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		100		100
3	Classroom Wages (a)		843		843
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 943	\$	\$ 943
10	SUM OF line 9, col. 1 and 2 (e)	\$ 943			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number HERITAGE MANOR-MINONK# 0041392

Report Period Beginning:

01/01/01

Ending:

12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V	Staff		Outside Practitioner		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
		Line & Column Reference	Units of Service	Cost	(other than consultant)					
					Units	Cost				
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 5,876	\$		\$ 5,876	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			4,865			4,865	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			23,186	32		23,218	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescripts				216,969		216,969	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39/3				2,229			2,229	13
14	TOTAL			\$		\$ 36,156	\$ 217,001		\$ 253,157	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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pt adj -4954
st adj 2709
Ot adj -704

drugs 91587

STATE OF ILLINOIS

Page 17

Facility Name & ID Number HERITAGE MANOR-MINONK

0041392

Report Period Beginning: 01/01/01

Ending:

12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,584	\$	1
2	Cash-Patient Deposits	4,071		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	298,030		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	592		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	701,602		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,008,879	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	1,183,273		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	134,514		16
17	Accumulated Depreciation (book methods)	(259,567)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	19,028		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,102,248	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,111,127	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 39,188	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,071		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,674		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,763		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,116		32
33	Accrued Interest Payable	3,739		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 174,551	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,081,041		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,081,041	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,255,592	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 855,535	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,111,127	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 417,809	1
2	Restatements (describe):		2
3	audit Adjustment	0	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 417,809	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	437,726	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 437,726	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 855,535	24 *

* This must agree with page 17, line 47.

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